**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m(^2)</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

**To be given:**

**Cycle(s) #:**

**Date of Previous Cycle:**

- [ ] Delay treatment ______ week(s)
- [ ] CBC & diff, platelets day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 \times 10^9/L, Platelets greater than or equal to 75 \times 10^9/L, Creatinine Clearance greater than 50 mL/minute**

**Dose modification for:**

- [ ] Hematology
- [ ] Age/ECOG
- [ ] Other Toxicity ______________________

Proceed with treatment based on blood work from __________________________

**CHEMOTHERAPY:**

- [ ] Repeat in three weeks

capecitabine 1250 or 1000 mg/m\(^2\) (circle one) x BSA x (_______%) = _________mg PO bid with food x 14 days

(Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

- [ ] Return in **three** weeks for Doctor and Cycle _________
- [ ] Return in **six** weeks for Doctor and Cycle _____ & _____.
- [ ] Last Cycle. Return in ______ week(s)

CBC & diff, platelets, creatinine prior to each cycle

If clinically indicated:  
- [ ] BUN
- [ ] Albumin
- [ ] Bilirubin
- [ ] Alk Phos
- [ ] GGT
- [ ] ALT
- [ ] CEA
- [ ] CA 19-9

- [ ] INR weekly
- [ ] INR prior to each cycle

- [ ] Other tests:

- [ ] Weekly Nursing Assessment

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**